

YOUR REHABILITATION

Rehabilitation with a Specialist Groin Physiotherapist will be needed for all patients after surgery

Enthusiastic participation in rehabilitation enables return to sport between 6 to 8 weeks after surgery. In the first few weeks, power walking, stationary cycling and swimming are initially recommended. Thereafter, the referring Sports Physician or Physiotherapist takes over with a specific treatment protocol. Preventative physiotherapy for players who are at risk of groin injury is encouraged and certain strategies have been devised which consist of the use of the Swiss ball for increasing flexibility and strength of muscles arising from or acting across the hip joint, concentrating on symmetrical conditioning and stabilising pelvic core abdominal muscles are encouraged.

www.harbourstsportsphysio.com.au demonstrates an excellent post-operative rehabilitation programme that has proven to be satisfactory.

How soon can I get back to playing sport after surgery ?

After surgery, up to 90% of those operated upon will get back to their pre-injury level of activity. This is achieved with a rehabilitation programme arranged by your Sports Physician and Physiotherapist.

Return to full activity training and playing would take 8-12 weeks.

How soon can I get back to work after surgery ?

As noted, after surgery, up to 90% of those operated upon will get back to their pre-injury level of activity. You will probably be OK to return to light duties 2 weeks after surgery, then back to full duties after about 4 weeks.

YOUR OPERATION continued

Discharge from Hospital

Although some patients prefer to have Day-Only surgery, Dr Garvey prefers you to stay at least one night in Hospital to minimise any inconvenience if post-operative urinary retention (full bladder) occurs. Most patients have completed their Hospital stay by 1 to 2 days and so you could plan to be out of Hospital 24-48 hours after your operation.

Pain Control

Your Anaesthetist will provide you with the most suitable form of post-operative pain relief and this might include patient controlled analgesia (PCA) where you have to push a button to deliver pain-killer into your bloodstream directly, or possibly injections of pain-killer into your bottom. After operation, you will be given a discharge prescription for pain-reducing tablets.



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After hours: 0414 279 444

YOUR APPOINTMENT:

Date

Time

YOUR OPERATION:

Date

Hospital

Tel

Please ring the day before to confirm admission time.

FASTING

Nothing to eat or drink, **not even water**, from midnight the night before your operation.

ASPIRIN (or aspirin-like medications to thin your blood) and **ARTHRITIS** medication (eg **CELEBREX**) will need to be stopped **ONE WEEK** before your procedure.



Dr John Garvey, Surgeon

www.groinpainclinic.com.au



GROIN PAIN INJURY

Chronic groin pain may be due to disruption of the inguinal (groin) canal due to a “sports hernia”, together with other injuries such as Adductor tendinopathy, conjoint tendon tear and osteitis pubis and nerve entrapment. The injury is also called Footballers groin. (In the Northern hemisphere, this condition is known as “Gillmore’s groin”).

Injury to the groin is a very common sporting injury and may occur in about 25-50% of athletes. Long-standing groin pain without a detectable hernia is termed occult hernia, sports hernia or athletic pubalgia, and often doesn’t respond to conservative treatment with physiotherapy and rehabilitation.

A wide range of sports, which require repetitive twisting, turning and kicking movements can cause these injuries. These injuries are not frequently seen in women, but about 10% of cases have been encountered. The typical patient will often have had ongoing groin pain for between 2 – 3 years before getting something done about it. There may be co-existing injuries of tendons and hip joint (labral tear).

Diagnosis

The onset of pain is usually gradual, but in some sports such as touch football, a sudden injury due to slipping on a moist grass surface or during a specific tackle or ruck can cause a sudden disruption. The pain is typically well localised to the area around the pubic bone and pain is often also described in the region of the Adductor tendon insertion with radiation to the testicle and also around the bottom area (perineum) to the other side.

Examination

Physical examination usually demonstrates pain in the pubic area and lower abdomen on resisted sit-up, and squeezing the knees against the examiner’s fist (Adductor squeeze test) may also be a positive clinical sign. Rarely is there a positive cough impulse to indicate a hernia is present.

Radiology

Plain X-rays of the pelvis, ultrasound, dynamic CT scanning and Magnetic Resonance Imaging (MRI) scan are the most reliable forms of diagnostic radiology. Herniography is not favoured because of the incidence of false negative cases and because of the risk of accidentally sticking a needle into the intestines. Sometimes bone scan is necessary to confirm the diagnosis of osteitis pubis.

Treatment

Surgical treatment is usually only considered after a three to six month trial period of non-operative treatment in the hands of an experienced Sports Physician and/or a Physiotherapist. About 20% of patients will show some improvement in a six month period.



YOUR OPERATION

90% of those operated upon will get back to their pre-injury level of activity

Surgical Techniques

The surgery is a variant of the standard open hernia repair (not “key hole”), which involves fastening the deep fascia with a blanket stitch, and a darn repair of the muscles of the posterior wall of the inguinal canal. Other injuries such as a conjoint tendon tear may need to be fixed by sutures placed along the pubic crest and release of a torn or damaged Adductor tendon may also be combined with the hernia operation. Occasionally release of the entrapped Obturator or lateral femoral cutaneous nerve will be also necessary.

Success Rates of Surgery

The rates of success in surgery are reported to vary between 63 and 93%, but there is only one prospective randomised control trial yet published from Sweden.

Post-Operative Complications

Surgery proceeds without complication in almost all cases. However, in rare cases, complications can occur, and it is appropriate to mention some of these.

- There are complications that can take place after any operation under general anaesthetic, but Dr Garvey only uses the best Hospitals with the lowest infection rates, and the best Anaesthetists to keep any operative complications to the lowest achievable rates.
- Post-operative urinary retention (full bladder) occurs in about 5 to 10% of male patients. This is usually a complication of the anaesthetic given and the amount of pain-killer used in the first 24 hours after the operation. If this complications occurs, a urinary catheter needs to be inserted and then removed the following morning. If unable to void a second time, then the catheter has to stay in a couple of days longer and a consultation from a Specialist Urologist may need to be arranged.
- Other possible complications include post-operative haemorrhage or haematoma (bruising) in the wound which may need to be evacuated at a second operation, but usually the body is able to absorb this bruising into the tissues without another operation. The artery to the testicle could also be caused to go into spasm by the mere fact of opening up the groin canal and retracting the spermatic cord out of the way to perform the operation. However, this is a theoretical risk and this has not been encountered in Dr Garvey’s large series of operations.
- Injury to the nerves in the groin by being entrapped in scar tissue can also occur rarely, and if this happens, the wound has to be opened and the nerves have to be freed from the scar tissue. This is a very late complication and has only very seldom been encountered. [\(more information overleaf...\)](#)



YOUR SURGEON



Dr John F.W. GARVEY

Dr Garvey (Med) MBBS (NSW) D.Phil (Oxon) FACS FRACS CIME
GENERAL & DIAGNOSTIC SURGEON

Dr Garvey has 20 years’ experience in diagnosing groin problems, and he has operated on hundreds of chronic groin pain patients including elite athletes such as players of Rugby, AFL, soccer, basketball, cricketers, long distance runners, etc.

Dr Garvey has worked as a Specialist Surgeon in private practice in Sydney for the last 20 years. He trained at St Vincent’s Hospital and Royal Prince Alfred Hospitals in Sydney and at the John Radcliffe Hospital in Oxford. Dr Garvey undertook his basic research training in the Nuffield Department of Surgery in the University of Oxford under the supervision of Sir Peter Morris.

Dr Garvey has a specific interest in **chronic groin pain** and specialises in diagnosis and surgery for groin disruption in elite athletes. In 1999 he established the **Groin Pain Clinic** at South Sydney Sports Medicine and this pioneering work has resulted in the resurrection of many sportsmen’s careers. Over the years, many elite athletes have been referred for treatment including many international athletes, who have undergone successful surgery, and this includes many professional footballers who had been unable to play for many months or years because of undiagnosed injuries of the groin.

Dr Garvey consults and performs surgery on a regular basis and performs a wide range of other **procedures** including hernia, breast, digestive tract endoscopy, varicose veins, vasectomy and other various procedures. Dr Garvey has a special interest in **breast cancer research and treatment**, and is an active member of the Breast Section of the Royal Australasian College of Surgeons. He has delivered papers on the Risk Factors in Breast Cancer at medical meetings.

Dr Garvey also undertakes **medico-legal** assessments and opinions and holds the qualification of Certified Independent Medical Examiner (CIME) from the American Board of Independent Medical Examiners (ABIME), indicating competence in giving an independent medico-legal opinion for Solicitors, Workers’ Compensation, Third Party cases, etc. Dr Garvey is recognised as an approved specialist (AMS) for the Workers Compensation Commission (NSW) and has approved training with the Motor Accident Authority, (MAA). He also serves on the supplementary Appeals Panel for the Workers’ Compensation Commission of NSW.

